



October 23, 2026

The Honorable Phil Weiser
Colorado Attorney General
Ralph L. Carr Judicial Building
1300 Broadway, 10th Floor
Denver, CO 80203

RE: ATA ACTION COMMENTS REGARDING COLORADO AUTOMATED DECISION-MAKING TECHNOLOGY & CHATBOT SAFETY RULEMAKING

Dear Attorney General Weiser and staff of the Colorado Attorney General's Office,

On behalf of ATA Action, I am writing to share our perspective on Colorado's Automated Decision-Making Technology & Chatbot Safety Rulemaking. Ahead of this rulemaking being finalized, our organization believes there are key areas where further clarity is necessary, especially regarding how the rule will impact out-of-state telehealth providers treating Colorado patients and providing guidance for healthcare entities that are not covered by HIPAA.

ATA Action is the affiliated policy and legislative advocacy arm of the American Telemedicine Association. ATA Action is the leading advocacy organization dedicated to advancing policy and accelerating the adoption of technology-enabled healthcare. Working collaboratively with federal and state legislators and policymakers, our organization drives industry momentum by influencing legislative and regulatory developments in telehealth, virtual care, remote patient monitoring, artificial intelligence in health, health data privacy, private sector healthcare investment, and more. We represent a diverse membership – including hospital systems, technology companies, professional associations, direct-to-consumer digital health providers, payers, pharmaceutical manufacturers, digital therapeutics developers, and remote monitoring organizations.

The final rules should confirm that Colorado-licensed telehealth providers serving Colorado patients qualify for the exemption in Section 6-1-1708(3).

Section 6-1-1708(3)(a) exempts HIPAA covered entities doing business in Colorado, and their business associates, from Sections 6-1-1701 through 6-1-1706, except for consequential employment-related decisions. For covered entities that are healthcare providers, however, Section 6-1-1708(3)(b) applies the exemption only if the provider is “operating from a location within Colorado.”

Neither the statute nor the interim draft rules explain what this phrase means for telehealth. Many ATA Action members deliver care to Colorado patients through Colorado-licensed clinicians who may not be physically in Colorado at the time of service. Requiring the clinician's physical presence in the state to qualify for the exemption would produce results the General Assembly is unlikely to have intended. For example, two Colorado-licensed physicians could use the same clinical decision support tool to treat the same Colorado patient and face entirely different obligations. The only difference would be where each physician was sitting during the visit and thus Colorado patients would have different rights depending on a fact they often do not know and cannot control. Furthermore, Colorado has also established itself as a leader in expanding patient access to telehealth care through the out-of-state telehealth provider registration system enacted by [SB24-141](#). The strides this system made in patient access to out-of-state

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telehealth providers could be undermined by the lack of clarity surrounding the implementation of these rules.

A physical-presence reading is also difficult to reconcile with Colorado’s regulation of telehealth. [Colorado Revised Statutes 12-240-104](#) defines telemedicine as “the delivery of medical services through technologies that are used in a manner that is compliant with the federal “Health Insurance Portability and Accountability Act of 1996”, Pub.L. 104-191, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, or treatment of a patient while the patient is located at an originating site and the individual who provides the services is located at a distant site” with no implication that the distant site need be within Colorado. Under applicable Colorado authorities, a Colorado-licensed clinician treating a patient located in Colorado is practicing in Colorado, and the care is delivered at a location within Colorado. *See, e.g.,* [Colorado Revised Statutes 12-245-217](#), [Colorado Med. Board Policies](#) pg. 1010, [3 CCR 721-1](#).

The Attorney General has authority to adopt rules “to implement and clarify” Part 17 (Sec. 6-1-1706(5)(a)). We respectfully request that the final rules include the following clarification:

For purposes of section 6-1-1708(3)(b), C.R.S., a Health-Care Provider is “operating from a location within Colorado” when it provides health-care services to a patient located in Colorado through an individual licensed or otherwise authorized to practice in Colorado, including through telehealth, regardless of that individual’s physical location at the time of service.

The final rules should provide guidance and examples for healthcare deployers that are not HIPAA covered entities

Healthcare services are one of the seven covered domains under the Act (Sec. 6-1-1701(6)(f)). The interim draft provides illustrative and helpful sector-specific examples for employment, education, housing, financial services and insurance. The lengthy rules do not contain a single sector-specific example with implementing guidance for healthcare providers using ADMT. The draft’s only healthcare clinical reference comes in Rule 4.3(C)(1) discussing third-party ADMT and involves an *exempt* HIPAA-covered physician, thus offering no guidance on how the Act applies to healthcare providers who remain subject to it.

That gap matters for a significant segment of the healthcare market. ATA Action represents many providers that serve Colorado patients but are not HIPAA covered entities, because they do not conduct HIPAA standard electronic transactions, typically because they do not bill insurance. Many of these providers voluntarily follow HIPAA-level privacy and security practices, yet they fall fully within the scope of the Act and the ongoing rulemaking.

Unlike deployers in every other covered domain, the proposed rules have no examples showing when an ADMT output materially influences a consequential decision in a healthcare setting, or what an adverse outcome disclosure should say. The draft rules’ only clinical reference shows why this guidance is needed. In Rule 4.3(C)(1) on third party ADMT, a diagnostic company runs a laboratory-developed test that uses AI computations to indicate that a patient would not respond to a particular treatment. Based on that result, a HIPAA-covered physician decides not to provide the treatment. The rule concludes that this



is a consequential decision, that the physician is the deployer, and that no deployer obligations apply because the physician is exempt under Section 6-1-1708.

Yet, if the physician runs a practice that does not bill insurance, and is therefore not a HIPAA covered entity, the same test, the same clinical judgment and the same treatment decision could now trigger the Act's host of requirements, including a pre-use notice, a written adverse outcome disclosure within 30 days stating the principal reasons and any score the tool produced, a process to request information about the tool and its data sources, data access and correction rights and meaningful human review of the treatment decision. Nothing in the clinical encounter differs; the only difference is whether the patient paid with insurance or out of pocket. Cash-pay and direct-to-consumer practices are disproportionately small and independent, and many serve patients who are uninsured or may have any number of reasons for seeking care outside of their insurance. These practices would bear the full compliance burden for the same clinical conduct that their HIPAA-covered counterparts may engage in with only a general notice.

We recognize the scope of the HIPAA exemption is set by statute and ATA Action [raised these concerns](#) throughout the legislative process. Yet, this disparity underscores the need for the Attorney General's Office to use its authority to "implement and clarify" the Act (Sec. 6-1-1706(5)(a)) so that its application to clinical care is workable and proportionate. We ask that the final rules include more clarity and healthcare examples in Rules 6.2 and 7.5 that address the following four questions.

- (a) *Clinical judgment and reconsidering the presumption of material influence.* Under Rule 6.1(A), an ADMT output is presumed to materially influence a decision if the decision-maker reviewed it and it is consistent with the outcome. Clinical decision support tools, such as risk scores, alerts, and dosing or diagnostic recommendations, are reviewed by clinicians by design. They are frequently consistent with the clinician's ultimate decision precisely because well-validated tools are accurate, not invariably because the AI system was a substantial factor. As drafted, the presumption could capture nearly every use of clinical decision support embedded in an electronic health record. We ask the Attorney General's Office to reconsider the presumption of material influence altogether or significantly narrow it to only instances where there is a causal link or the decision was not supported by other information the decision-maker considered.

If the rulemaking retains this presumption, the final rules should establish – through clarity or an example – that a licensed clinician's documented, independent professional judgment, based on the patient's history, examination and clinical findings, is sufficient to rebut the presumption. Such an approach would preserve appropriate oversight of consequential AI-driven decisions without unnecessarily extending regulatory requirements to healthcare applications where independent clinical judgment remains the primary driver of patient care decisions.

- (b) *Independent clinical judgment and the rebuttal standard.* Similarly, Rule 6.1(B)(3) does permit rebuttal of the presumption, but only when a clinician's independent review covers information that is "substantial" and relevant to the decision. The exact meaning of "substantial" in this context is uncertain. But more critically, many clinical decision support tools exist precisely because they can draw on more of the patient's medical information — lab trends, medication histories, prior encounter notes — than a clinician can feasibly review line by line during a single patient encounter. A clinician who examines the patient, consults the relevant findings, and reaches an independent clinical decision that meets the standard of care under the Colorado Medical Practice Act should not have to additionally demonstrate that their review also met an



arbitrary “substantial” scope under the ADMT Act. We ask the Attorney General’s Office to delete “substantial” from Rule 6.1(B)(3) and rely instead on “relevant” alone, which is also the standard the Act itself contemplates when defining Meaningful Human Review (Sec. 6-1-1701(15)(a) “relevant, available primary evidence”).

- (c) *What counts as an “adverse outcome” in clinical care.* The Act defines an adverse outcome as a decision that “denies, terminates, revokes, or materially reduces or restricts” a consumer’s access to, eligibility for, or the provision of an opportunity or service (Sec. 6-1-1701(1)(a)). Clinical care routinely involves decisions not to prescribe, or to recommend a different course of treatment, made in the patient’s interest. Suppose a clinician uses a covered ADMT and declines to prescribe weight-loss medication because of a contraindication. Is that an adverse outcome that requires a written disclosure within 30 days? Under Rule 7.4(B), that disclosure would have to state the principal reasons and disclose any score the tool produced. Treating every contraindication-driven clinical decision as a formal Adverse Outcome would require generating numerous disclosures with little consumer protective value while risking two counterproductive effects: discouraging clinicians from using the clinical tools that flag contraindications in the first place and requiring patients to receive a bureaucratic “adverse outcome” notice for every treatment decision their own clinician made specifically to protect them from harm. We request guidance on “adverse outcomes” that distinguish clinical treatment determinations made in the patient’s interest from decisions about access to or eligibility for healthcare services, such as whether a provider will accept a patient or whether a patient qualifies for a program.
- (d) *Meaningful human review in a clinical setting.* There is further confusion for healthcare stakeholders as to compliance obligations should a consumer have the right to “meaningful human review.” Rule 8.7(E) lists “required medical care” as a basic human need in the commercial-reasonableness analysis. Rule 8.7(C)(5) separately bars ADMT from assisting in the review. Read together, these provisions could subject certain clinical decisions to a second review, conducted without the clinical decision support tools that may themselves reflect the standard of care. We request clarification of three points:
- That existing clinical processes, such as a second opinion or review by another appropriately licensed clinician, satisfy the meaningful human review requirement;
 - That reviewers may use clinical tools that are part of the standard of care; and
 - How the consumer’s right to review interacts with the treating clinician’s professional judgment and licensure obligations.

The General Assembly directed that disclosure requirements be clarified through rulemaking that “accounts for sector-specific practices” (Sec. 6-1-1704(4)(a)). It also authorized the Attorney General to adopt illustrative examples clarifying “materially influence” (Sec. 6-1-1706(5)(b)). We respectfully request that the final rules add healthcare examples to Rules 6.2 and 7.5, developed with input from the provider community, or, alternatively, indicate where the Attorney General intends to exercise enforcement discretion in the healthcare context. ATA Action would welcome the opportunity to provide representative telehealth fact patterns to assist in that effort.

We appreciate the opportunity to comment. ATA Action shares the Attorney General’s commitment to protecting Coloradans and to ensuring that automated tools are deployed responsibly and with appropriate oversight. We urge further clarity to be established in the key areas discussed above before finalizing this



rulemaking to avoid disruptions or complications for Coloradans' access to high-quality telehealth care. If you have any questions or would like to discuss further, please contact me at hyoung@ataaction.org.

Kind regards,

A handwritten signature in black ink that reads "Hunter Young". The signature is written in a cursive, flowing style.

Hunter Young
Head of State Government Relations
ATA Action